Vermont: A Case History for Supporting National Guard Troops and Their Families

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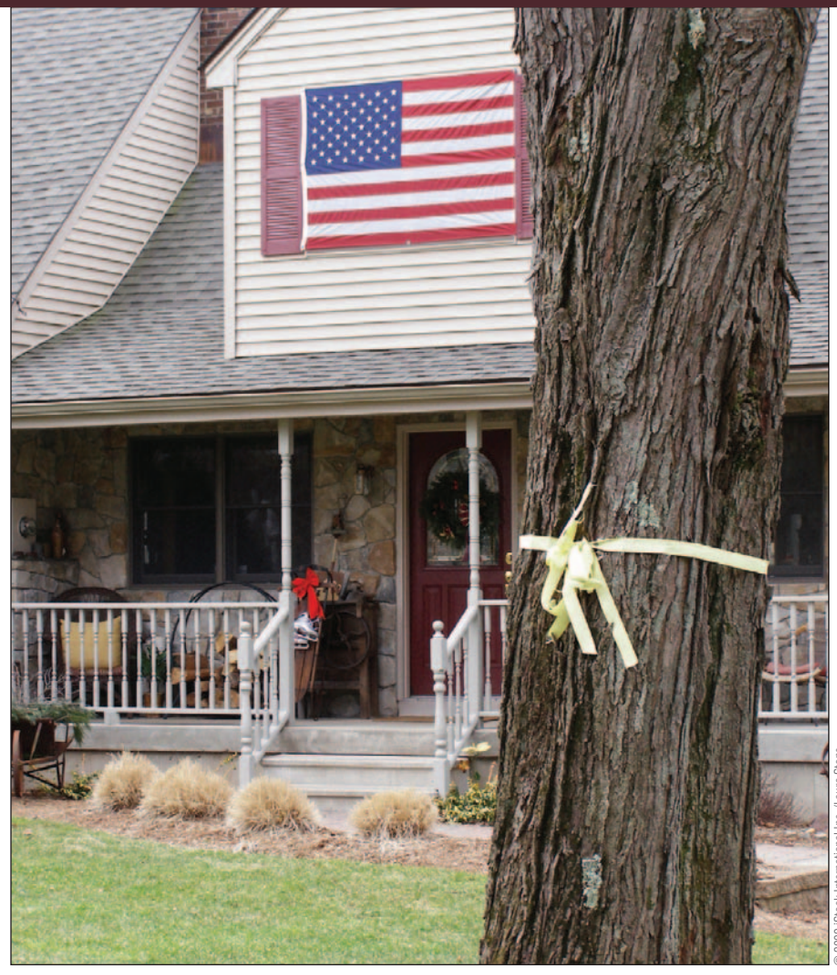
The current wars in Afghanistan and Iraq present many challenges to service members and their families. The traditional military cycle of deployment exposes troops and their families to the tension and apprehension of predeployment anticipation; troops to the dangers of the war zone; families to the challenge of carrying on without the missing service member; and, finally, troops



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and their families with post-deployment reintegration. The reunion and reintegration phase can be especially problematic because the effects of deployment are complicated by the difficulty of picking up where things left off before their separation.[1]

Under the best of conditions, service members must readjust to life on the home front, as well as managing the common reactions that occur for most troops following time in the war zone. For example, readjusting to partners who may have assumed new roles as household heads during this period, reintegrating with children who have matured, or handling the initial nightmares that often take place. Young children may not recognize the returned parent. Adolescents may resent a new imposition of discipline or surveillance that they experience as an unwelcomed change in the family environment. Parents may need to be careful not to stifle a new sense of independence their son or daughter gained during deployment, and partners may find that their relationship must be renegotiated because each partner may seem significantly different than before. As one service member exclaimed, "You have to become reacquainted and fall in love all over again."

Under the worst of conditions, a fragile predeployment relationship may shatter during the separation and resist all efforts at reconstruction. Divorce rates often increase. Also, the stress of deployment may precipitate clinically significant mental and neurological conditions such as posttraumatic stress disorder (PTSD), depression, alcohol/drug misuse, anger management problems, and/or traumatic brain injury (TBI).

Many of these problems are not new, but instead are the traditional challenges faced by service members and their families throughout history. The current wars present new challenges, as well. These include the constant intensity of combat in the war zone, the concussive

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injuries produced by roadside bombs and suicide bombers, the increased role of women in warfare, and the greater involvement of National Guard and Military Reserve troops in the war zone.[2,3] Gratefully, the rate of survival of those wounded in action has increased (90% compared with 75% in previous wars); however, this raises the resulting risk of PTSD and TBI. Finally, many Active Duty and Reserve component troops have served in multiple deployments, thereby increasing the risk of injury to service members and the risk of family disruption to those left behind. At the same time, an enhanced level of concern and awareness by the medical and general communities has led to increased action at the federal, state, and local levels to address such problems.

Many recent commission reports have highlighted the importance of adequately meeting an increased need for mental health services among troops returning from Iraq and Afghanistan and providing increased support for families.[4-6] The need is high partially because of the fact that National Guard and Reserve members of the armed forces make up approximately 50% of the service members deployed in the current conflicts in which our U.S. armed forces are involved. These citizen-soldiers and their family members do not have the support systems available to families of active duty military families living on military bases.

In this report, we present an ongoing case history of combined efforts by the professional and local communities to meet the needs of service members and families in Vermont before, during, and after deployments to Afghanistan and Iraq. We recognize that other states have responded to these needs with excellent programs that evolved differently than Vermont's. Therefore, we present this report with the understanding that our approach is but one of several possible strategies to help returning troops and their families with reintegration. Vermont is a small, rural state that does not have a military base within its borders. It does, however, have a National Guard camp, which on a per-capita basis has sustained more injuries and fatalities to its service members than any other state. We offer these observations with the hope that lessons learned during the past 5 years may be helpful elsewhere as communities work to assist troops and families negotiate the military cycles of often repeated deployments.

TRADITIONAL CLINICAL APPROACHES AND PUBLIC MENTAL HEALTH APPROACHES

The conceptual approach used in Vermont derives from lessons learned following the September 11, 2001, attacks on the World Trade Center and the Pentagon. During the aftermath of that catastrophe, it became apparent to both policy makers and practitioners that a two-tiered approach was needed.[7]

Clinical care and preventative measures were both required.

On the one hand, a traditional clinical approach was needed for early detection and treatment for individuals with clinically significant problems resulting from exposure to a specific traumatic event.[8] In addition, the intense surge of service-seeking among survivors in the New York metropolitan area demanded large-scale recruitment and training of mental health practitioners in disaster mental health and evidence-based practices.[9] We face a similar challenge today as thousands of mental health practitioners are attempting to meet the surge in demand for services by returning soldiers and their families. Here we describe how mental health services, based primarily at the state's only Veterans Affairs (VA) medical center, were expanded, reorganized, and integrated with other state and local resources. In addition, we describe how the unique demands of an often-young cohort of new veterans, reluctant to seek or utilize treatment, necessitated outreach efforts very different from traditional office-based models of care.

On the other hand, a public health approach was needed to complement the aforementioned clinical initiatives. Such an approach emphasized wellness rather than illness, prevention rather than treatment, and most importantly, the active participation of the community at large.[7] We describe how the efforts of a few chaplains in the Vermont National Guard, recently returned service members, their families, and VA mental health professionals rapidly grew into a robust partnership: the VT Military, Family and Community Network. The Network involves the participation of the Vermont National Guard, the state's Agency of Human Services, VA resources, other veterans' organizations and, most importantly, the civilian community at large.

The empirical rationale for developing the Network is consistent with the finding that social support is the most powerful protective factor in preventing the later development of PTSD among individuals exposed to a traumatic event.[10] The Network's rapid and successful evolution is because of several differences between the current wars and the Vietnam War. Most importantly, Americans support their troops despite deep political divisions about the war itself. This is quite different from the social context regarding the Vietnam War, where political opposition to the war tragically translated into opposition to the soldiers who risked their lives. Because of this significant change in the public's attitude, it is now easy to generate enthusiasm and corroboration for a community-based program to support the troops. Other important differences from the Vietnam War era are new developments in diagnosis and effective treatments and a commitment among mental health practitioners to prevent chronic mental illness and suffering among the newest veterans and their families.

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THE CLINICAL PROGRAM AT THE VERMONT VA MEDICAL CENTER

Efforts to prepare clinical programs and staff to meet the needs of the returning Vermont service members began when the first troops were being deployed to Afghanistan in 2002. Clinicians at the White River Junction VA Medical Center, armed with an array of evidence-based interventions developed in the decades of research since the Vietnam War, prepared to screen, assess, and offer these treatments to this new generation of returning men and women. An intensive 21-day partial hospital PTSD program formed the cornerstone of treatment. The intensive program and the PTSD outpatient programs provided psychoeducation, family treatment, case management, cognitive processing and prolonged exposure psychotherapies, group therapies, pharmacotherapy, and recovery services (including supported employment, self-care, and peer support). The overall PTSD program was interwoven with other mental health programs to address the multiple comorbidities seen in combat veterans. In addition, the acute inpatient psychiatry ward developed a 2-week treatment track for those thought in need of the most intensive treatment.

Primary Mental Health Care Clinic

In summer 2004, anticipating rising numbers of new veterans expected to seek treatment in a time of declining resources, Vermont's VA mental healthcare reorganized its services to establish the first fully open access integrated care mental health clinic in the Veterans Health Administration. This Primary Mental Health Care clinic, located in the Primary Care clinic and staffed by one therapist and one psychiatrist, offers immediate access to comprehensive mental health evaluation and treatment.[11,12] The numbers of new patients evaluated and treated in the first year of operation nearly tripled from prior years. Because the clinic is indistinguishable from general primary care and available at the time of their primary care visit, patients report increased satisfaction due to reduced mental health stigma and ease of access. Ongoing care for the majority of patients with relatively straightforward mental health problems is provided in this clinic, freeing other resources to concentrate on providing care for more complex illness, including PTSD.

By the time the clinic opened, the first wave of National Guard troops deployed to Afghanistan had returned, and early deployments to Iraq and Kuwait were underway. Despite the easy

ORDER
Observe
What am I seeing?
Reflect
Does it fit "Distressed"?
Document
Who/what/where/when?
Evaluate
Who needs to know?
Report
Inform higher authority

Distractive
Irritable
Substance abuse
Tired
Resists help
Easily angered
Sad
Startled easily
Evident confusion
Denies problems

Stay alert

Figure. ORDER card. Side 1 (left). Side 2 (right).

access, this group of returnees did not choose to engage treatment in significant numbers. Many presented for one visit at the VA or Vet Centers and then moved on. The Operation Iraqi Freedom/Operating Enduring Freedom Cohort program planned in the intensive PTSD day hospital, and other subspecialty treatment programs, never materialized. No one was interested. The few who did present for treatment usually were brought in by family members, police, chaplains, or other community members. The people treated in the inpatient setting generally chose to leave after achieving safety, and few completed the 2-week program there. They expressed a strong desire to return to their previous lives, symptomatic or not.

Thus, the challenge was that despite reports from community agencies and National Guard family programs, only a small number of returning troops were engaging in the various treatment options that we had established. However, the low clinical utilization of mental health services by returned service members was apparently not an accurate barometer of need. It became clear that the secondary and tertiary prevention approach in place would not be effective with this cohort of combat veterans.

Guard Families

In January 2005, in collaboration with the National Guard leadership and Family Readiness Program, the Vermont Department of Health, and the Vet Centers, the VA Mental Health Department shifted to a primary prevention approach directed at bolstering family and community supports. Mental Health negotiated a contract with the Vermont Guard that allowed VA clinicians to provide treatment to Guard family members during deployment. This led to many referrals, which often came from soldiers, commanders, state agencies, family members, and the Guard Family Assistance Centers. In some cases, a plea for help from a soldier in Iraq on behalf of the spouse at home led to this family outreach. In some cases even parents of deployed troops received treatment from VA providers.

During this time, VA staff members provided in-service education to community mental health centers in regions with a high prevalence of deployment. Various provider groups across Vermont hosted VA clinicians as they presented detailed educational programs meant to assist those with little experience with the military to better understand the issues specific to military families during deployment.

Since 2005, key VA staff members have held monthly clinical planning meetings with National Guard leadership and chaplains. During times of heavy deployment, these meetings have served to plan the timing of preclinical interventions; activities to take place at demobilization stations where troops are held between returning to the United States and the ultimate return to their homes. Now a team of VA and National Guard staff meets each large military group that returns. In addition to group debriefings, counselors and others remain available for individual troops throughout the week at the demobilization site.

ORDER Program

Early in the collaboration, VA staff also developed the ORDER program, a secondary prevention effort. The key elements of the program are summarized on a two-sided pocket card (see the Figure). Guard commanders and personnel were trained to recognize the distress often seen in service members and, therefore, those at risk of developing stress disorders. This would potentially facilitate referrals and care. The ORDER training quickly became an integral part of pre- and post-deployment briefings.

Getting Troops to Engage in Treatment

The military families readily sought and engaged in treatment. The troops, however, remained resistant to treatment, particularly to the evidence-based psychotherapies honed in recent years. Early evaluation revealed that, although the open access nature of the Mental Health Clinic encouraged individuals to present for an evaluation, few of the service members readily accepted referral and treatment in the more specialized programs. A telephone survey, performed as part of the department's quality improvement program, suggested to two primary reasons for this: a lack of interest in attending weekly sessions and an enduring belief

that PTSD is an untreatable illness. In response, the clinic increased its focus on psychoeducation and encouraged troops to come to the open-access clinic on a self-directed basis for supportive, educational, and problem solving sessions prior to referral to more systematic treatment options.

The final component of the secondary prevention model is active outreach to locate veterans thought at risk. In early 2007, shortly after the return of the last large group deployed, the Guard hired five veterans to work as outreach specialists to seek out service members whom others reported to be troubled or to have "disappeared." These outreach specialists visit returnees in their community and act as resource guides to help them access treatment and social services. In early 2008 the program expanded to 11 outreach specialists and VA staff now working closely with them, providing peer specialist training and supervision. With this additional training, these outreach specialists can now screen for mental illness and traumatic brain injury and bring or connect troops in need to medical and social services.

This generation of returnees differs in many ways from its predecessors. Life moves at a faster pace and makes use of technology in a way previous generations could barely imagine. Although cognitive behavioral therapies remain standard practice, Vermont's current clinical efforts are developing to meet the service member's lifestyle, with increased use of internet resources, interactive audiovisual telecommunications (telepsychiatry, teletherapy), virtual reality treatment, and computer-aided cognitive retraining for those with brain injury. Services are also being brought closer to home in this rural area with a mobile TBI assessment and treatment program and VA psychiatric services at local armories and community mental health centers.

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With a large redeployment of Vermont Guard troops looming, attention is again turning to predeployment interventions. The attention of many Guard members is moving away from treatment and toward readiness for deployment. Many now express concern that the benefit of treatment carries the risk of making them less effective soldiers. They are often caught between their competing roles as military and family members. In the new era of repeated deployments of citizen-soldiers, this is the next significant challenge for clinicians to address.

CONTINUING A VERMONT PUBLIC HEALTH APPROACH

In 2005, concerned about their comrades returning from deployment, a group of military chaplains, Family Readiness Center personnel, and top command of the Vermont National Guard approached the local VA Medical Center and the VA National Center for Posttraumatic Stress Disorder (www.ncptsd.va.gov) in Vermont for help. At the same time that VA mental health was evolving, the Guard wanted to be better prepared to deal with potential problems among returning troops and wanted to help get those in need into care. They were also concerned that service members and their families did not have adequate community support systems. The Vermont National Guard wanted help to ease the readjustment process for troops and their families.

A small group of VA and Guard personnel began meeting monthly to further discuss issues needing attention. They soon realized that the first order of business was to hold a training program for commanders, community service personnel, and providers who work with veterans or their family members so that they would be prepared to meet the challenges of readjustment. It had become apparent that many services and resources existed; however, many did not know about services other than the ones that they themselves provided. There was also a great need for more direct information and support for service members and their families and for methods of overcoming stigma.

Initial Conferences and Outreach

In August 2005, an initial conference was held at the Medical Center to bring relevant parties together and to explore areas that needed attention. In preparation for the event, the *Vermont Yellow Book of Resources* was developed. It contains information on local resources, military resources provided by the National Guard, VA services, employment and educational resources, child care, and relationship counseling, for example. This book is organized topically to guide users. The *Yellow Book* made its debut at the conference, which was attended by military commanders and staff, VA staff, and family program personnel. Conference presentations were followed by break out groups to foster more in-depth discussion on relationship issues, mental health confidentiality and stigma, employment, substance abuse and sleep problems, and diagnosis and treatments. Attendees gained a clearer

understanding of the need that existed and began to network with each other.

Members of the network continued to hold more events and present at community events. The main focus of these trainings was to educate attendees on common posttraumatic stress reactions, resilience, reintegration issues, and available helpful resources. For example, two evening family trainings were held at National Guard armories. The Army-developed Battlemind (www.battlemind.army.mil) presentation was used and discussion between family members encouraged. More than 70 family members attended each session and evaluations were unanimously favorable.

Taking Things to the Next Level

Over the next year, this collaboration grew into a formal statewide network: the Vermont Military, Family, and Community Network (MFCN). The Network includes representatives from the Vermont Agency of Human Services, VA, the VT National Guard and Family Program, chaplains, Vet Centers, the Vermont State Guard. The Employer Support for the Guard and Reserves (ESGR) and many other local area providers became involved, including VA mental health. Vermont state officials, including the Governor and the state Office of Veterans Affairs, became involved. Religious leaders, partners of deployed troops, local veteran groups, and military family members also joined, creating a grass-roots foundation that built a sustainable and far-reaching community of individuals united by their determination to make the readjustment process as good as it could be for returning troops.

In June 2006, the first of several statewide conferences was held for community members, providers, and anyone else interested in helping veterans and their families. This all-day event was the first step in reaching out to the broader community. It included the Governor, the Adjutant General, congressional representatives, and was attended by almost 150 guests.

The Network now includes six local task forces. The National Guard's Family Assistance Centers serve as hubs from which these groups are based. The state's Agency of Human Services also assigned one Field Services Director from each respective geographic location to the cause. This allows both a civilian and a military liaison to co-

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lead each of the six taskforces. The goals of the local taskforces, like those of the MFCN, are to increase networking and partnerships between existing services and agencies; communicate and share common problems; identify gaps in services; overcome barriers; and educate troops, their families, and community members on the difficulties of reintegration.

Three factors seem essential for the network's success and sustainability. First, both military members and civilians must work together to identify gaps in services and help fill those gaps through an existing resource or through a network effort. Second is perpetual growth of the network, which fosters greater discussion and awareness in the community. Third is maintaining regular meetings to keep Network members in touch with one another and aware of various services/resources that exist or are in development. The core planning group meets monthly and meets together with the local taskforces quarterly.

The MFCN has filled a major gap since many troops, family members, and even service providers themselves didn't know about what services were available. The MFCN has partnered with VT 211, a statewide telephone hotline that provides information and a referral service (www.vermont211.org) for all Vermont residents. VT 211 made a special category in their database to draw attention to the wide array of services available for veterans, active duty service members, and their families. Many previously disconnected services are now tied together in one database, to which more resources are added and updated regularly. The 211 service (www.211.org) is available in the majority of U.S. states and can be easily adapted to include veteran specific resources.

The MFCN encourages anyone to join. At a minimum, members can sign up for a listserve to learn about related news and educational events in their area. Others help organize local training events and promote awareness and participation for the community. The network continues to grow as new people join from many walks of life, united by their desire to help returning veterans. The MFCN has even attracted people from the neighboring states of New Hampshire, New York, Maine, and Massachusetts.

Building on the success of the first conference, approximately every 6 months, one of the local taskforces holds a statewide/regional conference. At the second conference the effectiveness of this Network began to show. Communication between the military, community service providers, agencies, and others had significantly improved. Service providers and family members find it easier to access information, social support or professional assistance and share their own experiences. Based on its initial success and growing influence, we believe that we have developed a sustainable network that can support comprehensive community efforts to understand, pre-

vent, and deal with the lingering aftereffects of war on communities.

CONCLUSION

Many states have developed programs to ease the problems faced by service members and their families prior to, during, and following deployment to Iraq and Afghanistan. We share our experience in Vermont as one of several possible approaches to meet the needs of service members and their families. We believe that the strength of our approach is that it is based on a public health model that combines clinical, social, military, and community resources into a comprehensive package, which emphasizes primary, secondary, and tertiary prevention. After 4 years, this model of care has proven effective and sustainable. It can easily be adapted to meet the needs in other states as well.

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